

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

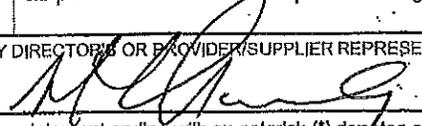
PRINTED: 06/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/13/2021
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NAME OF PROVIDER OR SUPPLIER MIDLANDS LIVING CENTER L L C	STREET ADDRESS, CITY, STATE, ZIP CODE 2462 NORTH BROADWAY COUNCIL BLUFFS, IA 51503
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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<p>✓ ✓ F 000</p> <p>F 580 SS=D</p>	<p>INITIAL COMMENTS</p> <p>Correction Date <u>June 18, 2021</u></p> <p>The recertification survey and investigation of complaint 97102-C was conducted on May 10 - 13, 2021 and resulted in the following deficiencies.</p> <p>Complaint 97102-C was substantiated.</p> <p>See Code of Federal Regulations (42CFR) Part 482, Subpart B-C</p> <p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)</p>	<p>F 000</p> <p>F 580</p>	<p>F 580 -</p> <ol style="list-style-type: none"> To correct this deficiency as it relates to Residents #45, the Nurses identified on the Diabetic Administration Record was provided education on Notifying MD of VS/BS outside of parameters on May 18, 2021. To protect other residents in similar situations, all nurses were provided education on notifying MD of Blood sugars or Vital Signs outside of ordered parameters on the Point Click Care Communication Board dated May 24 and June 9, during shift huddles beginning May 17. To ensure that the problem does not recur, the Nurse Manager or designee will complete Diabetic Administration Record audits for 5 residents with orders to notify MD of VS/Blood sugars outside parameters weekly. To monitor performance and to make sure that solutions are permanent, the Director of Nursing or designee will report the findings from weekly Diabetic Administration Record audits at the monthly QAPI Committee Meeting This will be done for three months or as compliance is determined by the QAPI Committee. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 06/08/2021
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	<p>Continued From page 1</p> <p>is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to notify the physician of a blood sugar of over 400 as directed by the physician's order for 1 of 1 residents reviewed (Resident #45). The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set assessment tool dated 4/23/21, Resident #45 had diagnoses that included acute kidney failure, heart failure, and diabetes mellitus and revealed he the</p>	F 580		

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F 580	<p>Continued From page 2</p> <p>resident scored 13 of 15 possible points on the Brief Interview for Mental Status (BIMS) test which meant the resident demonstrated intact cognitive abilities. The MDS documented the resident as totally dependent on 1 staff for transfers and remained independent with meals. The MDS also documented Resident #45 required extensive assist of two staff for bed mobility.</p> <p>The Electronic Health Record (EHR) revealed the resident admitted to hospice services on 3/17/21.</p> <p>A physician's order directed staff to administer Novolog Solution 100 UNIT/ML injected according to sliding scale; if 200-249 give 4 units, 250- 299 give 8 units, 300- 349 give 12 units, 350-399 give 16 units, and 400 - 999 give 20 units. Notify the physician with blood sugars above 400.</p> <p>The Blood Sugar Summary located the EHR recorded Resident #45 had a blood sugar of 413 on 4/16/21 at 11:45 AM and also on 4/18/21 at 4:37 PM.</p> <p>The Medication Administration summary documented staff administered 20 units of Novolog Solution on 4/16/21 at 11:30 AM and also on 4/18/21 at the 4:30 PM.</p> <p>Review of the EHR revealed no documentation to show staff notified the physician of the resident's elevated blood sugar on 4/16/21 and 4/18/21.</p> <p>In an interview on 5/11/21 at 4:30 p.m., the Director of Nursing (DON) stated she would contact the hospice service to see if they had documentation that indicated facility staff notified them of the resident's blood sugar when it</p>	F 580		
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F 580	Continued From page 3 exceeded 400. On 5/12/21 at 1:05 PM, Staff B Registered Nurse (RN) Nurse Manager reported she had contacted hospice and they reported they had no documentation to confirm the facility notified them of the elevated blood sugars on either 4/16/21 or 4/18/21. During an interview on 5/12/21 at 2:21 PM, the DON stated the facility did not have a policy for physician notification, but said the facility followed the standard of care. She reported she expected nursing staff to read and follow physician orders and notify the physician regarding any blood sugar values out of the normal parameters.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(l)(1)-(7) §483.10(l) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-- §483.10(l)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		

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F 584	<p>Continued From page 4</p> <p>§483.10(l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(l)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(l)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(l)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(l)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(l)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to maintain resident rooms in a clean, comfortable, and homelike manner. The facility reported a census of 64 residents.</p> <p>Findings include: Observation in Resident # 9's room on 05/10/21 12:50 PM revealed popcorn on the floor under her bedside stand by her chair and broken wood on the inner side of the bathroom door that left a rough spot. In an interview at that time, Resident #9 stated she it upset her that the popcorn remained on the floor from last night and added she didn't like the "torn-up" bathroom door..</p>	F 584	<ol style="list-style-type: none"> To correct this deficiency as it relates to Resident # 9's room was cleaned on 5/10. Resident #9's bathroom door was repaired on May 14. Rooms 206 and 212 walls were repaired and painted on May 20. Rooms 208, 210, 216, 217, 218 bathroom doors were repaired on June 15, 2021. To protect other residents in similar situations, a facility wide audit for the presence of chipped, cracked, scratched, spills, and/or damages to doors and walls was completed prior to May 21, 2021. To ensure that the problem does not recur, Maintenance staff or designee will complete preventative maintenance schedules each month as an on-going process. The Environmental Services Supervisor or designee will complete random repair audits of 5 rooms weekly. To monitor performance and to make sure that solutions are permanent, the Environmental Services Supervisor or designee will report the findings from weekly repair audits at the monthly QAPI Committee Meeting. This will be done for three months or as compliance is determined by the QAPI Committee.

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F 584	Continued From page 5 Observation on 05/11/21 at 12:25 PM revealed 8 of 15 rooms reviewed required repairs as follows: a. The on the walls in Rooms 212 and 206 contained nicked and scratched areas in the paint. b. The bathroom doors in Rooms 216, 210, 218, 208 included wood damage. c. The bathroom door in Room 215 had something spilled on both the front and back. d. The bathroom door in Room 217 contained scratches on the front of it. On 05/12/21 at 10:45 AM, Staff E, Environmental Services Director, stated they do check the rooms for repair needs, although painting walls is an ongoing project. She reported the facility had lasso planned to repair the doors and had also applied protectors to some of the bathroom doors. At 2:00 p.m., Staff E said housekeepers clean rooms every day, but they do not have a set pattern or order of whose room they clean when due to each resident's needs or care times and how they vary on a daily basis. In a subsequent interview on 05/12/21 at 03:10 PM, Staff #E stated housekeeping had addressed the bathroom door in Room 215 and had successfully removed the marks on both sides.	F 584			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(I) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (I) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658			

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F 658	<p>Continued From page 6</p> <p>by:</p> <p>Based on observation, clinical record review, and staff interviews, the facility staff failed to prime an insulin flex pen prior to administering the medication as required one of six residents reviewed (Resident #42). The facility reported a census of 66 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. According to the Minimum Data Set (MDS) assessment tool, Resident #42, had diagnoses of diabetes mellitus, coronary artery disease, urinary tract infection, atrial fibrillation, hemiplegia after cerebral infarction affecting the right side, and chronic obstructive pulmonary disease. The MDS revealed the resident received injections for diabetic medications seven of seven days during the "look back" period. <p>A care plan dated 5/3/21 documented the resident as at risk for hypoglycemia and hyperglycemia related to a diagnosis of diabetes mellitus. The care plan directed staff to check blood sugars and administer insulin as prescribed.</p> <p>A physician order directed staff to administer Novolog (fast-acting insulin) subcutaneously (SQ) before meals and at bedtime. according to a sliding scale based on blood glucose checks as follows:</p> <p>Blood Sugar Values/Novolog Insulin</p> <p>150 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units;</p>	F 658	<ol style="list-style-type: none"> 1. To correct this deficiency as it relates to Residents #42, Staff A was provided education on professional standards of practice when administering medications on May24,2021 2. To protect other residents in similar situations, all Nurses will be provided education on professional standards of practice on proper Priming of Insulin Pens by June 17. 3. To ensure that the problem does not recur, three random competency evaluations regarding Priming of Insulin Pens will be completed weekly by the Infection Preventionist or designee. 4. To monitor performance and to make sure that solutions are permanent, the Infection Preventionist or designee will report the findings from weekly medication administration competency checks at the monthly QAPI Committee Meeting. This will be done for three months or as compliance is determined by the QAPI Committee. 	

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F 658	<p>Continued From page 7</p> <p>351 - 400 = 12 units over 400 call physician.</p> <p>In an observation on 5/12/21 at 8:00 AM, Staff A checked Resident #42's blood glucose level and obtained a value of 195. Staff A, checked the orders, obtained the Novolog pen and capped it with a new needle. Staff A then entered the room, wiped the resident's abdomen with an alcohol swab, clicked the pen to four and administered the insulin. The staff member failed to prime the insulin pen prior to administration of the medication.</p> <p>The Novolog manufacturer guide dated May 2016 directed: 1) Attach a new needle 2) Turn the dose selector to two units 3) Press and hold the dose button. 4) Ensure a drop appears.</p> <p>In an interview on 5/12/21 at 1:55 PM, the Director of Nursing (DON), reported she expected staff to prime the pen. When asked for a policy, the DON reported facility staff used the manufacturer guide for directions.</p>	F 658			